

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11, 13, 14, Film G232 8-18-58 et

9008

Item 22 Film 232 8-21-58 et

CERTIFICATE OF DEATH

09007

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Charles b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata Md. c. LENGTH OF STAY IN lb Physicians Memorial Hospital | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newburg, Md. d. STREET ADDRESS 7 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Edwin First Brazil Middle Brown Last | | 4. DATE OF DEATH Month August Day 7 Year 1958 | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH August 4/58 |
| 9. AGE (In years last birthday) yrs. 19 | | IF UNDER 1 YEAR Months 19 Days 19 Hours 19 Min. 19 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Newburg, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Joseph Louis Wills | | 14. MOTHER'S MAIDEN NAME Grace Rebecca Brown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.0 DUE TO atelectasis Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO Post maturity (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 8-4 , 19 58 to 8-7 , 19 58 , that I last saw the deceased alive on 8-7 , 19 58 , and that death occurred at 7:25 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Lorenzo Lopez M.D. M.D. Physicians Memorial Hosp. La Plata Md. PHYSICIAN'S NAME (Type) LORENZO LOPEZ Physicians Memorial Hosp. La Plata Md | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8-7-58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Shiloh Cemetery | | 22d. LOCATION (City, town, or county) (State) Shiloh, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS | | 24a. REC'D BY REGISTRAR DATE AUG 8 '58 | |
| 24b. REGISTRAR'S SIGNATURE W. J. Smith | | | |

4000212XV5

CERTIFICATE OF DEATH

| | | | | | |
|------------------------------------|--|-----------------------------------|--|-----------------------------------|--|
| 1. Name of Deceased | | 2. Sex | | 3. Age | |
| 4. Date of Death | | 5. Time of Death | | 6. Place of Death | |
| 7. Cause of Death | | 8. Manner of Death | | 9. Signature of Registrar | |
| 10. Signature of Medical Officer | | 11. Signature of Coroner | | 12. Signature of Police Officer | |
| 13. Signature of Health Officer | | 14. Signature of Social Worker | | 15. Signature of Family Member | |
| 16. Signature of Burial Officer | | 17. Signature of Cemetery Officer | | 18. Signature of Undertaker | |
| 19. Signature of Transport Officer | | 20. Signature of Funeral Home | | 21. Signature of Religious Leader | |
| 22. Signature of Other Official | | 23. Signature of Other Official | | 24. Signature of Other Official | |
| 25. Signature of Other Official | | 26. Signature of Other Official | | 27. Signature of Other Official | |
| 28. Signature of Other Official | | 29. Signature of Other Official | | 30. Signature of Other Official | |
| 31. Signature of Other Official | | 32. Signature of Other Official | | 33. Signature of Other Official | |
| 34. Signature of Other Official | | 35. Signature of Other Official | | 36. Signature of Other Official | |
| 37. Signature of Other Official | | 38. Signature of Other Official | | 39. Signature of Other Official | |
| 40. Signature of Other Official | | 41. Signature of Other Official | | 42. Signature of Other Official | |
| 43. Signature of Other Official | | 44. Signature of Other Official | | 45. Signature of Other Official | |
| 46. Signature of Other Official | | 47. Signature of Other Official | | 48. Signature of Other Official | |
| 49. Signature of Other Official | | 50. Signature of Other Official | | 51. Signature of Other Official | |
| 52. Signature of Other Official | | 53. Signature of Other Official | | 54. Signature of Other Official | |
| 55. Signature of Other Official | | 56. Signature of Other Official | | 57. Signature of Other Official | |
| 58. Signature of Other Official | | 59. Signature of Other Official | | 60. Signature of Other Official | |
| 61. Signature of Other Official | | 62. Signature of Other Official | | 63. Signature of Other Official | |
| 64. Signature of Other Official | | 65. Signature of Other Official | | 66. Signature of Other Official | |
| 67. Signature of Other Official | | 68. Signature of Other Official | | 69. Signature of Other Official | |
| 70. Signature of Other Official | | 71. Signature of Other Official | | 72. Signature of Other Official | |
| 73. Signature of Other Official | | 74. Signature of Other Official | | 75. Signature of Other Official | |
| 76. Signature of Other Official | | 77. Signature of Other Official | | 78. Signature of Other Official | |
| 79. Signature of Other Official | | 80. Signature of Other Official | | 81. Signature of Other Official | |
| 82. Signature of Other Official | | 83. Signature of Other Official | | 84. Signature of Other Official | |
| 85. Signature of Other Official | | 86. Signature of Other Official | | 87. Signature of Other Official | |
| 88. Signature of Other Official | | 89. Signature of Other Official | | 90. Signature of Other Official | |
| 91. Signature of Other Official | | 92. Signature of Other Official | | 93. Signature of Other Official | |
| 94. Signature of Other Official | | 95. Signature of Other Official | | 96. Signature of Other Official | |
| 97. Signature of Other Official | | 98. Signature of Other Official | | 99. Signature of Other Official | |
| 100. Signature of Other Official | | 101. Signature of Other Official | | 102. Signature of Other Official | |

DO NOT WRITE IN THESE SPACES

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 9 Film 233 9-11-58 et

09008

9009

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|---|---|---|---|---|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Charles</u> | | MARYLAND | | STATE <u>Md.</u> | | COUNTY <u>Charles</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Faulkner</u> | | LENGTH OF STAY (in this place) <u>Life</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Faulkner</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) <u>1</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <u>William</u> | | (Middle) <u>B.</u> | | (Last) <u>BUTLER Sr.</u> | | (Month) <u>Aug</u> (Day) <u>29</u> (Year) <u>1958</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>NEGRO</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH <u>Sept 17, 1868</u> | 9. AGE last birthday <u>90</u> yrs. | IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Orsterius Butler</u> | | | | 14. MOTHER'S MARDEN NAME <u>Elizabeth ANN Swann</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT & ADDRESS <u>Bel</u> <u>William B. Butler Jr, Alton, Md.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 420.1 IMMEDIATE CAUSE (A) <u>Cerebral occlusion</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Semil arterio-sclerotic disease</u> | | | | | | <u>10 years.</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) | | (County) (State) | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>June</u> <u>1950</u> , to <u>29 Aug.</u> <u>1958</u> , that I last saw the deceased alive on <u>29 Aug.</u> <u>1958</u> , and that death occurred at <u>11:00 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Howard M.D.</u> | | | | DATE SIGNED <u>29 Aug 58.</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | | | DATE THEREOF <u>9/1/58</u> | | NAME OF CEMETERY OR CREMATORY <u>St Ignatius</u> | |
| 24. REC'D BY REGISTRAR | | | | REGISTRAR'S SIGNATURE <u>Arthur L. House</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waltham, Md.</u> | |
| DATE <u>SEP 4 '58</u> | | | | | | | |

NOTIFICATION

THIS IS TO CERTIFY THAT THE FOLLOWING PERSON HAS BEEN DECEASED AND THAT THE DEATH HAS BEEN REPORTED TO THE LOCAL HEALTH DEPARTMENT. THE DEATH IS BEING REPORTED BY THE FOLLOWING PERSON:

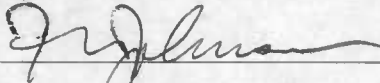

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

11/10/09

| | | | | | |
|---|--|--|--|---|--|
| <p>1. NAME OF DECEASED Charles</p> | | <p>2. SEX Male</p> | | <p>3. AGE 28</p> | |
| <p>4. PLACE OF BIRTH Charles</p> | | <p>5. PLACE OF DEATH Charles</p> | | <p>6. DATE OF DEATH 11/10/09</p> | |
| <p>7. CAUSE OF DEATH Heart Disease</p> | | <p>8. MANNER OF DEATH Natural</p> | | <p>9. SIGNATURE OF PHYSICIAN Dr. Charles</p> | |
| <p>10. SIGNATURE OF REPORTER Dr. Charles</p> | | <p>11. SIGNATURE OF WITNESS Dr. Charles</p> | | <p>12. SIGNATURE OF DECEASED Charles</p> | |
| <p>13. SIGNATURE OF DECEASED Charles</p> | | <p>14. SIGNATURE OF DECEASED Charles</p> | | <p>15. SIGNATURE OF DECEASED Charles</p> | |
| <p>16. SIGNATURE OF DECEASED Charles</p> | | <p>17. SIGNATURE OF DECEASED Charles</p> | | <p>18. SIGNATURE OF DECEASED Charles</p> | |
| <p>19. SIGNATURE OF DECEASED Charles</p> | | <p>20. SIGNATURE OF DECEASED Charles</p> | | <p>21. SIGNATURE OF DECEASED Charles</p> | |
| <p>22. SIGNATURE OF DECEASED Charles</p> | | <p>23. SIGNATURE OF DECEASED Charles</p> | | <p>24. SIGNATURE OF DECEASED Charles</p> | |
| <p>25. SIGNATURE OF DECEASED Charles</p> | | <p>26. SIGNATURE OF DECEASED Charles</p> | | <p>27. SIGNATURE OF DECEASED Charles</p> | |
| <p>28. SIGNATURE OF DECEASED Charles</p> | | <p>29. SIGNATURE OF DECEASED Charles</p> | | <p>30. SIGNATURE OF DECEASED Charles</p> | |
| <p>31. SIGNATURE OF DECEASED Charles</p> | | <p>32. SIGNATURE OF DECEASED Charles</p> | | <p>33. SIGNATURE OF DECEASED Charles</p> | |
| <p>34. SIGNATURE OF DECEASED Charles</p> | | <p>35. SIGNATURE OF DECEASED Charles</p> | | <p>36. SIGNATURE OF DECEASED Charles</p> | |
| <p>37. SIGNATURE OF DECEASED Charles</p> | | <p>38. SIGNATURE OF DECEASED Charles</p> | | <p>39. SIGNATURE OF DECEASED Charles</p> | |
| <p>40. SIGNATURE OF DECEASED Charles</p> | | <p>41. SIGNATURE OF DECEASED Charles</p> | | <p>42. SIGNATURE OF DECEASED Charles</p> | |
| <p>43. SIGNATURE OF DECEASED Charles</p> | | <p>44. SIGNATURE OF DECEASED Charles</p> | | <p>45. SIGNATURE OF DECEASED Charles</p> | |
| <p>46. SIGNATURE OF DECEASED Charles</p> | | <p>47. SIGNATURE OF DECEASED Charles</p> | | <p>48. SIGNATURE OF DECEASED Charles</p> | |
| <p>49. SIGNATURE OF DECEASED Charles</p> | | <p>50. SIGNATURE OF DECEASED Charles</p> | | <p>51. SIGNATURE OF DECEASED Charles</p> | |
| <p>52. SIGNATURE OF DECEASED Charles</p> | | <p>53. SIGNATURE OF DECEASED Charles</p> | | <p>54. SIGNATURE OF DECEASED Charles</p> | |
| <p>55. SIGNATURE OF DECEASED Charles</p> | | <p>56. SIGNATURE OF DECEASED Charles</p> | | <p>57. SIGNATURE OF DECEASED Charles</p> | |
| <p>58. SIGNATURE OF DECEASED Charles</p> | | <p>59. SIGNATURE OF DECEASED Charles</p> | | <p>60. SIGNATURE OF DECEASED Charles</p> | |
| <p>61. SIGNATURE OF DECEASED Charles</p> | | <p>62. SIGNATURE OF DECEASED Charles</p> | | <p>63. SIGNATURE OF DECEASED Charles</p> | |
| <p>64. SIGNATURE OF DECEASED Charles</p> | | <p>65. SIGNATURE OF DECEASED Charles</p> | | <p>66. SIGNATURE OF DECEASED Charles</p> | |
| <p>67. SIGNATURE OF DECEASED Charles</p> | | <p>68. SIGNATURE OF DECEASED Charles</p> | | <p>69. SIGNATURE OF DECEASED Charles</p> | |
| <p>70. SIGNATURE OF DECEASED Charles</p> | | <p>71. SIGNATURE OF DECEASED Charles</p> | | <p>72. SIGNATURE OF DECEASED Charles</p> | |
| <p>73. SIGNATURE OF DECEASED Charles</p> | | <p>74. SIGNATURE OF DECEASED Charles</p> | | <p>75. SIGNATURE OF DECEASED Charles</p> | |
| <p>76. SIGNATURE OF DECEASED Charles</p> | | <p>77. SIGNATURE OF DECEASED Charles</p> | | <p>78. SIGNATURE OF DECEASED Charles</p> | |
| <p>79. SIGNATURE OF DECEASED Charles</p> | | <p>80. SIGNATURE OF DECEASED Charles</p> | | <p>81. SIGNATURE OF DECEASED Charles</p> | |
| <p>82. SIGNATURE OF DECEASED Charles</p> | | <p>83. SIGNATURE OF DECEASED Charles</p> | | <p>84. SIGNATURE OF DECEASED Charles</p> | |
| <p>85. SIGNATURE OF DECEASED Charles</p> | | <p>86. SIGNATURE OF DECEASED Charles</p> | | <p>87. SIGNATURE OF DECEASED Charles</p> | |
| <p>88. SIGNATURE OF DECEASED Charles</p> | | <p>89. SIGNATURE OF DECEASED Charles</p> | | <p>90. SIGNATURE OF DECEASED Charles</p> | |
| <p>91. SIGNATURE OF DECEASED Charles</p> | | <p>92. SIGNATURE OF DECEASED Charles</p> | | <p>93. SIGNATURE OF DECEASED Charles</p> | |
| <p>94. SIGNATURE OF DECEASED Charles</p> | | <p>95. SIGNATURE OF DECEASED Charles</p> | | <p>96. SIGNATURE OF DECEASED Charles</p> | |
| <p>97. SIGNATURE OF DECEASED Charles</p> | | <p>98. SIGNATURE OF DECEASED Charles</p> | | <p>99. SIGNATURE OF DECEASED Charles</p> | |
| <p>100. SIGNATURE OF DECEASED Charles</p> | | <p>101. SIGNATURE OF DECEASED Charles</p> | | <p>102. SIGNATURE OF DECEASED Charles</p> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| BALTIMORE, 18 | | | | | | | | | | 13641 | |
|--|--|---------------------------------|---|---|---|---|---|--|---|---|--|
| Item 18 Film 236 12-22-58 ams | | | | | | | | | | | |
| 11931 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | Reg. Dist. No. | |
| 1. PLACE OF DEATH a. COUNTY Charles MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Charles | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata | | | c. LENGTH OF STAY IN 1b 2 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Issue | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physician's Memorial | | | | | d. STREET ADDRESS | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Cannady | | | 4. DATE OF DEATH Month Day Year August 29 19 58 | | | | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE Col. | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 8/26/58 | | 9. AGE (In years last birthday) yrs. 3 | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Md. | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Melvin Cannady | | | | | 14. MOTHER'S MAIDEN NAME Agnes Hotor | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | INFORMANT | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 days | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that I attended the deceased from 8-26 , 19 58 , to 8/29 , 19 58 , that I last saw the deceased alive on 8/28/58 , 19 58 , and that death occurred at 4 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | | | | | |
| ACTUAL SIGNATURE  M.D. | | | | | PHYSICIAN'S NAME (Type) F. M. Johnson, M.D. La Plata, Md. 8/29/58 | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 22b. DATE THEREOF 8/29/58 | | 22c. NAME OF CEMETERY OR CREMATORY Holy Ghost | | | 22d. LOCATION (City, town, or county) (State) Issue, Md. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Melvin Cannady, Father | | | | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE DEC 15 '58 | | 24b. REGISTRAR'S SIGNATURE  | | |

2066203XVV

106

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9010

CERTIFICATE OF DEATH

09009

Reg. Dist. No.

| | | | |
|---|---------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COBB ISLAND | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Cobb Island | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First EDWARD Middle Nathaniel Last DARCEY | | 4. DATE OF DEATH Month August Day 21 Year 1958 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 13, 1880 |
| 9. AGE (In years last birthday) 78 yrs. | | IF UNDER 1 YEAR: Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | | 10b. KIND OF BUSINESS OR INDUSTRY Retired | |
| 11. BIRTHPLACE (State or foreign country) Somerset, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Nathen Dorsey | | 14. MOTHER'S MAIDEN NAME Mary Stacks | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 578-03-0351 | |
| 17. INFORMANT (Son) Horace Darcey, 6112-N. 31st. Arlington, Va. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute cardiac dilatation 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) hypertension DUE TO (c) arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH 10 min. 10 yrs. 20 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from the year of 1956 to 21 day , 1958, that I last saw the deceased alive on 1957 , and that death occurred at 10:10 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE F. M. Johnson M.D. | | ADDRESS (Street, city or town, state) La Plata, Md. DATE SIGNED 8-21-58 | |
| PHYSICIAN'S NAME (Type) F. M. JOHNSON M.D. | | La Plata, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Aug. 24, 1958 | |
| 22c. NAME OF CEMETERY OR CREMATORY Christ Church Cemetery | | 22d. LOCATION (City, town, or county) (State) Wayside, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Michael Funeral Home, Inc. Address La Plata, Maryland | | 24a. REC'D BY REGISTRAR AUG 27 '58 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | |

10000

STATE OF NEW YORK - BUREAU OF

CERTIFICATE OF DEATH

2010

WILLIAM BOND

DECEASED

| | | | |
|-------------------------|--|------------------------------|--|
| Name of Deceased | | Date of Death | |
| Sex | | Age | |
| Place of Birth | | Usual Residence | |
| Cause of Death | | Manner of Death | |
| Physician's Signature | | Medical Examiner's Signature | |
| Date of Certificate | | Place of Death | |
| Signature of Registrar | | Signature of Coroner | |
| Signature of Minister | | Signature of Priest | |
| Signature of Undertaker | | Signature of Burial Place | |
| Signature of Family | | Signature of Friends | |
| Signature of Neighbors | | Signature of Community | |
| Signature of Church | | Signature of Synagogue | |
| Signature of Cemetery | | Signature of Funeral Home | |
| Signature of Undertaker | | Signature of Burial Place | |
| Signature of Family | | Signature of Friends | |
| Signature of Neighbors | | Signature of Community | |
| Signature of Church | | Signature of Synagogue | |
| Signature of Cemetery | | Signature of Funeral Home | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9011 CERTIFICATE OF DEATH

09010

Reg. Dist. No.

| | | | |
|---|-------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Charles</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head</u> | | c. LENGTH OF STAY IN 1b <u>52 yrs</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head</u> | |
| | | d. STREET ADDRESS <u>1</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Russell</u> Last <u>Eastburn</u> Sr | | 4. DATE OF DEATH Month <u>8</u> - Day <u>17</u> Year <u>1958</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1-11-98</u> |
| 9. AGE (In years last birthday) <u>60</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman - Electrician</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Naval Packer</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Hampton, Va</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Samuel G. Eastburn</u> | | 14. MOTHER'S MAIDEN NAME <u>Lydie Smithson</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>7402</u> | |
| 17. INFORMANT <u>Edward R. Eastburn Jr.</u> | | Address <u>Insest St SE. Washington 28. D. C.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Heart Disease</u> DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>14 yrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>1/11</u> , 19 <u>58</u> , to <u>8/17</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8/10</u> , 19 <u>58</u> , and that death occurred at <u>3 P</u> M, from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) DATE SIGNED <u>5 Indian Head Ave</u> <u>8/17/58</u> | |
| ACTUAL SIGNATURE <u>Frank G. Susan</u> M.D. | | | |
| PHYSICIAN'S NAME (Type) <u>Frank A. Susan M.D.</u> | | <u>Indian Head. MD</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>8-20-58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u> | 22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros.</u> | | 24a. REC'D BY REGISTRAR <u>1661 19th St SE Washington D.C.</u> DATE <u>AUG 19 '58</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |

CERTIFICATE OF DEATH

1911

Age 21

| | | | | | | | | | | | | | | | |
|------------------|--|----------------|--|-----------------|--|-------------------|--|----------------|--|---------------|--|----------------|--|--------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY | | COUNTY | | STATE | |
| JAMES H. HARRIS | | Male | | 21 | | 1890 | | BALTIMORE | | BALTIMORE | | BALTIMORE | | MARYLAND | |
| OCCUPATION | | CAUSE OF DEATH | | MANNER OF DEATH | | PERIOD OF ILLNESS | | DATE OF DEATH | | TIME OF DEATH | | PLACE OF DEATH | | CITY | |
| Clerk | | Typhoid Fever | | Natural | | 10 days | | 1911 | | 10:00 AM | | BALTIMORE | | BALTIMORE | |
| FATHER'S NAME | | MOTHER'S NAME | | SPOUSE'S NAME | | CHILDREN | | EDUCATION | | RELIGION | | RACE | | COLOR | |
| JAMES H. HARRIS | | MARY H. HARRIS | | None | | None | | High School | | Protestant | | White | | Caucasian | |
| PREVIOUS ILLNESS | | TREATMENT | | HOSPITAL | | PHYSICIAN | | NURSE | | BURIAL | | CITY | | COUNTY | |
| None | | None | | None | | Dr. J. H. Harris | | None | | None | | BALTIMORE | | BALTIMORE | |
| TESTED BY | | TESTED BY | | TESTED BY | | TESTED BY | | TESTED BY | | TESTED BY | | TESTED BY | | TESTED BY | |
| J. H. Harris | | J. H. Harris | | J. H. Harris | | J. H. Harris | | J. H. Harris | | J. H. Harris | | J. H. Harris | | J. H. Harris | |

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE.

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09011

9012

CERTIFICATE OF DEATH

Reg. Dist. No.....

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED | |
| COUNTY <i>Charles</i> | MARYLAND | STATE <i>MD</i> | COUNTY <i>Charles</i> |
| CITY (If outside corporate limits, write RURAL and give nearest town) <i>Indian Head</i> | LENGTH OF STAY (in this place) <i>83 yrs</i> | CITY (If outside corporate limits, write RURAL and give nearest town) <i>Indian Head</i> | STREET ADDRESS (If rural give location) <i>1</i> |
| 3. NAME OF DECEASED (Type or Print) <i>Henry</i> <i>Hawkins</i> | | 4. DATE OF DEATH (Month) <i>August</i> (Day) <i>8</i> (Year) <i>1958</i> | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>Negro</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>widowed</i> | 8. DATE OF BIRTH <i>1874</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>laborer</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i> | 9. AGE last birthday <i>84</i> yrs. |
| 11. BIRTHPLACE (State or foreign country) <i>Port Tobacco, MD</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | |
| 13. FATHER'S NAME <i>John Hawkins</i> | | 14. MOTHER'S MAIDEN NAME <i>Letta Gray</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>216-12-4985</i> | |
| 17. INFORMANT & ADDRESS <i>Emelia Hawkins, Indian Head, Md.</i> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | 18. MEDICAL CERTIFICATION | |
| 431X IMMEDIATE CAUSE (A) <i>Acute Myocarditis</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>2 wks.</i> | |
| ANTECEDENT CAUSE(S) DUE TO (B) | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | <i>Pyelo-Nephritis</i> | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.) | | 21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/> | |
| 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <i>July 3, 1958</i> to <i>Aug 5, 1958</i> , that I last saw the deceased alive on <i>8/5</i> , 19 <i>58</i> , and that death occurred at <i>3:15 A.M.</i> from the causes and on the date stated above. | | | |
| SIGNATURE <i>Frank G. Duran</i> M.D. | | ADDRESS (Street, city, town, state) <i>Indian Head, MD</i> | |
| DATE <i>8-8-58</i> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 24. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE <i>Arthur S. Kneass</i> | |
| DATE <i>AUG 13 '58</i> | | 25. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home, Waldorf, Md.</i> | |

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 (10M)

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

09012

9013

Reg. Dist. No.....

| | | | | | | | |
|---|---------------------------------|---|--------------------------------------|--|--------------------------------|---|--------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Charles</u> | | STATE <u>Maryland</u> | | COUNTY <u>Charles</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Indian Head Md</u> | | LENGTH OF STAY (in this place) <u>41-Yrs</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Indian Head Md</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) <u>/</u> | | | |
| 3. NAME OF DECEASED (Type or Print) <u>Catherine Rebecca Jenkins</u> | | | | 4. DATE OF DEATH (Month) <u>8</u> (Day) <u>24</u> (Year) <u>58</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>W-US</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>2-18-1897</u> | 9. AGE last birthday <u>61</u> yrs. | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Prince George County Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>George R. Coombs</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Catherine A. Dixon</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT & ADDRESS <u>Thomas R. Jenkins--(Husband)</u> | | Indian Head Md. | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 1750 IMMEDIATE CAUSE (A) <u>Circulatory Collapse</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3-Hours</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>General Malignant Metastasis</u> | | | | | | <u>8-Mths</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Adeno-Carcinoma-thorax Ovarian</u> | | | | | | <u>1-Yr.</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Marked Ascites</u> | | | | | | <u>5-Mths</u> | |
| 19a. DATE OF OPERATION <u>7-11-57</u> | | 19b. MAJOR FINDINGS OF OPERATION <u>Cystic Ovary-Dr Vincent Hungerford, Providence Hospital, Washington D.C.</u> | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>8-24-58</u> , 19....., to <u>8-24-58</u> , 19....., that I last saw the deceased alive on <u>8-24-58</u> , 19....., and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Arthur S. Kraus</u> M.D. | | | | ADDRESS (Street, city, town, state) <u>Indian Head Md</u> | | DATE SIGNED <u>8-25-58</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> | | DATE THEREOF <u>8/26/1958</u> | | NAME OF CEMETERY OR CREMATORY <u>St. Charles Church Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Glymont, Charles, Md.</u> | |
| 24. REC'D BY REGISTRAR DATE <u>SEP 2 58</u> | | REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>AREHART FUNERAL HOME, INC.</u> | | ADDRESS <u>LA PLATA, MD.</u> | |

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH. IT IS TO BE SIGNED AND DATED BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH. IT IS TO BE SIGNED AND DATED BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

2013

REG. 100-10

1. USUAL RESIDENCE OF DECEASED

2. PLACE OF DEATH

3. DATE OF DEATH

4. SEX

5. AGE

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF DECEASED

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF CLERK

14. SIGNATURE OF JURY

15. SIGNATURE OF COURT

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF CONSTABLE

18. SIGNATURE OF JAILER

19. SIGNATURE OF PRISONER

20. SIGNATURE OF GUARD

21. SIGNATURE OF WARDEN

22. SIGNATURE OF DEPUTY WARDEN

23. SIGNATURE OF CHIEF CLERK

24. SIGNATURE OF CLERK

25. SIGNATURE OF DEPUTY CLERK

26. SIGNATURE OF JURY

27. SIGNATURE OF COURT

28. SIGNATURE OF SHERIFF

29. SIGNATURE OF CONSTABLE

30. SIGNATURE OF JAILER

31. SIGNATURE OF PRISONER

32. SIGNATURE OF GUARD

33. SIGNATURE OF WARDEN

34. SIGNATURE OF DEPUTY WARDEN

35. SIGNATURE OF CHIEF CLERK

36. SIGNATURE OF CLERK

37. SIGNATURE OF DEPUTY CLERK

38. SIGNATURE OF JURY

39. SIGNATURE OF COURT

40. SIGNATURE OF SHERIFF

41. SIGNATURE OF CONSTABLE

42. SIGNATURE OF JAILER

43. SIGNATURE OF PRISONER

44. SIGNATURE OF GUARD

45. SIGNATURE OF WARDEN

46. SIGNATURE OF DEPUTY WARDEN

47. SIGNATURE OF CHIEF CLERK

48. SIGNATURE OF CLERK

49. SIGNATURE OF DEPUTY CLERK

50. SIGNATURE OF JURY

51. SIGNATURE OF COURT

52. SIGNATURE OF SHERIFF

53. SIGNATURE OF CONSTABLE

54. SIGNATURE OF JAILER

55. SIGNATURE OF PRISONER

56. SIGNATURE OF GUARD

57. SIGNATURE OF WARDEN

58. SIGNATURE OF DEPUTY WARDEN

59. SIGNATURE OF CHIEF CLERK

60. SIGNATURE OF CLERK

61. SIGNATURE OF DEPUTY CLERK

62. SIGNATURE OF JURY

63. SIGNATURE OF COURT

64. SIGNATURE OF SHERIFF

65. SIGNATURE OF CONSTABLE

66. SIGNATURE OF JAILER

67. SIGNATURE OF PRISONER

68. SIGNATURE OF GUARD

69. SIGNATURE OF WARDEN

70. SIGNATURE OF DEPUTY WARDEN

71. SIGNATURE OF CHIEF CLERK

72. SIGNATURE OF CLERK

73. SIGNATURE OF DEPUTY CLERK

74. SIGNATURE OF JURY

75. SIGNATURE OF COURT

76. SIGNATURE OF SHERIFF

77. SIGNATURE OF CONSTABLE

78. SIGNATURE OF JAILER

79. SIGNATURE OF PRISONER

80. SIGNATURE OF GUARD

81. SIGNATURE OF WARDEN

82. SIGNATURE OF DEPUTY WARDEN

83. SIGNATURE OF CHIEF CLERK

84. SIGNATURE OF CLERK

85. SIGNATURE OF DEPUTY CLERK

86. SIGNATURE OF JURY

87. SIGNATURE OF COURT

88. SIGNATURE OF SHERIFF

89. SIGNATURE OF CONSTABLE

90. SIGNATURE OF JAILER

91. SIGNATURE OF PRISONER

92. SIGNATURE OF GUARD

93. SIGNATURE OF WARDEN

94. SIGNATURE OF DEPUTY WARDEN

95. SIGNATURE OF CHIEF CLERK

96. SIGNATURE OF CLERK

97. SIGNATURE OF DEPUTY CLERK

98. SIGNATURE OF JURY

99. SIGNATURE OF COURT

100. SIGNATURE OF SHERIFF

101. SIGNATURE OF CONSTABLE

102. SIGNATURE OF JAILER

103. SIGNATURE OF PRISONER

104. SIGNATURE OF GUARD

105. SIGNATURE OF WARDEN

106. SIGNATURE OF DEPUTY WARDEN

107. SIGNATURE OF CHIEF CLERK

108. SIGNATURE OF CLERK

109. SIGNATURE OF DEPUTY CLERK

110. SIGNATURE OF JURY

111. SIGNATURE OF COURT

112. SIGNATURE OF SHERIFF

113. SIGNATURE OF CONSTABLE

114. SIGNATURE OF JAILER

115. SIGNATURE OF PRISONER

116. SIGNATURE OF GUARD

117. SIGNATURE OF WARDEN

118. SIGNATURE OF DEPUTY WARDEN

119. SIGNATURE OF CHIEF CLERK

120. SIGNATURE OF CLERK

121. SIGNATURE OF DEPUTY CLERK

122. SIGNATURE OF JURY

123. SIGNATURE OF COURT

124. SIGNATURE OF SHERIFF

125. SIGNATURE OF CONSTABLE

126. SIGNATURE OF JAILER

127. SIGNATURE OF PRISONER

128. SIGNATURE OF GUARD

129. SIGNATURE OF WARDEN

130. SIGNATURE OF DEPUTY WARDEN

131. SIGNATURE OF CHIEF CLERK

132. SIGNATURE OF CLERK

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>CHARLES</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>LA PLATA</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>LA PLATA</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Physicians Memorial</i> | | d. STREET ADDRESS <i>1</i> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <i>JONES</i> | | 4. DATE OF DEATH Month Day Year <i>AUG 30 1958</i> | |
| 5. SEX <i>MALE</i> | 6. COLOR OR RACE <i>col</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>AUG 30 1958</i> |
| 9. AGE (In years last birthday) yrs. <i>3</i> | | 10. IF UNDER 1 YEAR Months Days Hours Min. <i>3 30</i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>infant</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>—</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>USA</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>WM. W BROWN</i> | | 14. MOTHER'S MAIDEN NAME <i>HELEN JONES</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>—</i> | |
| 17. INFORMANT <i>Helen Jones</i> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory failure</i> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Pneumonia</i> | | | INTERVAL BETWEEN ONSET AND DEATH <i>3 hrs.</i> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>Aug 30, 1958</i> , to <i>Aug 30, 1958</i> , that I last saw the deceased alive on <i>Aug 30, 1958</i> , and that death occurred at <i>2:30 PM</i> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>F. M. Johnson M.D.</i> | | DATE SIGNED <i>Aug 30, 58</i> | |
| PHYSICIAN'S NAME (Type) <i>F. M. JOHNSON M.D.</i> | | ADDRESS (Street, city or town, state) <i>La Plata, Md.</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 22b. DATE THEREOF <i>9/1/58</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Sacred Heart</i> | 22d. LOCATION (City, town, or county) (State) <i>La Plata, Md.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Crebert</i> | | 24a. REC'D BY REGISTRAR DATE <i>SEP 9 '58</i> | |
| 24b. REGISTRAR'S SIGNATURE <i>Arthur L. Evans</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9015

CERTIFICATE OF DEATH

09014

Reg. Dist. No.

| | | | |
|---|---------------------------------------|---|--|
| 1. PLACE OF DEATH o. COUNTY Charles MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Charles | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata | | c. LENGTH OF STAY IN 1b Lifetime | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicans Memorial Hospital | | /d. STREET ADDRESS | |
| e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last MARGARET S. JOHNS KEY | | 4. DATE OF DEATH Month Day Year August 3, 1958 | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 8, 1901 |
| 9. AGE (In years last birthday) yrs. 57 | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY at Home | |
| 11. BIRTHPLACE (State or foreign country) La Plata, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Columbas Norris | | 14. MOTHER'S MAIDEN NAME Mary Butler | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 216-22-4919 | |
| 17. INFORMANT Mr. Hobart Key (Husband) | | Address La Plata, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 DUE TO Hepatic failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cirrhosis of Liver DUE TO (c) 1956 | | INTERVAL BETWEEN ONSET AND DEATH 8-1-58 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1956 to 8-3-58 , that I last saw the deceased alive on 8-2-58 , and that death occurred at 6 M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE E. J. Edelen M.D. | | ADDRESS (Street, city or town, state) DATE SIGNED LA PLATA MD 8-3-58 | |
| PHYSICIAN'S NAME (Type) E. J. EDELEN M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 8/6/ 1958 | 22c. NAME OF CEMETERY OR CREMATORY Newtown Cemetery | 22d. LOCATION (City, town, or county) (State) Newtown, Charles County, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Archibald Funeral Home, Inc. | | ADDRESS La Plata, Maryland | |
| 24a. REC'D BY REGISTRAR AUG 7 '58 | | 24b. REGISTRAR'S SIGNATURE W. H. Smith | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09015

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

9016

Items 9, 11, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY Charles | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cobb Island | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cobb Island | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) Freida First McGuigan Last | | 4. DATE OF DEATH 8 Month 6 Day 1958 Year | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 9, 1932 1932 Year |
| 9. AGE (In years last birthday) 26 Years | | 10. UNDER 1 YEAR Months 10 Days 10 Hours 10 Min. | 11. UNDER 24 HRS. Months 10 Days 10 Hours 10 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) A. U. | | 10b. KIND OF BUSINESS OR INDUSTRY DC | |
| 11. BIRTHPLACE (State or foreign country) DC | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Julius Slader | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. Elmer S. McGuigan 22-191139 | |
| 17. INFORMANT Elmer S. McGuigan 22-191139 | | Address 22-191139 | |
| 18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vas. Accident 331X DUE TO Prob hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ?? DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 8-16-58 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE E. J. Edele | | DATE SIGNED 9-6-58 | |
| EXAMINER'S NAME (Type) E. J. EDELEN | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 7/9/58 | 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill | 22d. LOCATION (City, town, or county) (State) Swainsboro Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Walter McLaughlin | | 24a. REC'D BY REGISTRAR W. J. Edele DATE AUG 11 '58 | |
| 24b. REGISTRAR'S SIGNATURE W. J. Edele | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, "pending the word" in pencil in item 18. Give Pages 1, 2, 3 and 4 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1, 2, 3 and 4 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No. 09016

9017

| | | | | | | | |
|--|------------------------------|--|------------------------------------|--|--------------------------------------|--|--|
| 1. PLACE OF DEATH o. COUNTY <i>Charles</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Charles</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i> | | | | c. LENGTH OF STAY IN 1b <i>2 Days</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Physicians Memorial</i> | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <i>James</i> Middle <i>Carroll</i> Last <i>PICKERAL</i> | | | | 4. DATE OF DEATH Month <i>8</i> Day <i>28</i> Year <i>1958</i> | | | |
| 5. SEX <i>M</i> | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>8-26-58</i> | | 9. AGE (In years last birthday) yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>2</i> Days <i>7</i> Hours <i></i> Min. <i></i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Edward L. Pickeral</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Mary Esther Adams</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i> | | | | 16. SOCIAL SECURITY NO. <i>—</i> | | | |
| 17. INFORMANT <i>Edward L. Pickeral</i> | | | | Address <i>White Plains Md.</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Unknown</i> <i>795.5</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i></i> DUE TO (c) <i></i> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month <i>8</i> Day <i>26</i> Year <i>58</i> Hour <i>19</i> o. m. <i></i> p. m. <i></i> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from <i>8-26-58</i> to <i>8-28-58</i> , that I last saw the deceased alive on <i>8-27-58</i> , and that death occurred at <i>M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i></i> DATE SIGNED <i>8-28-58</i> | | | | | | | |
| ACTUAL SIGNATURE <i>R. J. Edelen</i> M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) <i>R. J. EDELEN</i> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>8/28/58</i> | | 22c. NAME OF CEMETERY OR CREMATORY <i>St. Josephs</i> | | 22d. LOCATION (City, town, or county) (State) <i>Pomfret, Md.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home, Waldorf, Md.</i> | | | | 24a. REC'D BY REGISTRAR DATE <i>SEP 2 '58</i> | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i> | |

2066335XV5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: All of this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9018

CERTIFICATE OF DEATH

09017

Reg. Dist. No.

| | | | |
|---|---------------------------|--|---------------------------------|
| 1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Charles</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Indian Head</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Physicians Memorial</i> | | d. STREET ADDRESS <i>Indian Head</i> | |
| 3. NAME OF DECEASED (Type or print) <i>Edward Wayne PICKLE</i> | | 4. DATE OF DEATH <i>AUG 26 1958</i> | |
| 5. SEX <i>M</i> | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>8-26-58</i> |
| 9. AGE (In years last birthday) yrs. <i>6</i> | | IF UNDER 1 YEAR Months <i>0</i> Days <i>20</i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <i>Robert Pickle</i> | | 14. MOTHER'S MAIDEN NAME <i>Doris B. Pickeral</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. <i>—</i> | |
| 17. INFORMANT <i>Robert Pickle, Indian Head Md.</i> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>irreversible shock</i> 773.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>hemorrhage from unclipped cord</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH <i>4 hrs</i> <i>4 hrs.</i> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>8-26</i> , 19 <i>58</i> , to <i>8-26</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>8-26</i> , 19 <i>58</i> , and that death occurred at <i>7:30 P.</i> M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>[Signature]</i> | | ADDRESS (Street, city or town, state) <i>La Plata, Md.</i> | |
| PHYSICIAN'S NAME (Type) <i>F. M. JOHNSON M.D.</i> | | DATE SIGNED <i>8-26-58</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>Aug. 27, 1958</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>St. Josephs</i> | | 22d. LOCATION (City, town, or county) (State) <i>La Plata, Md.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i> | | ADDRESS <i>La Plata, Md.</i> | |
| 24a. REC'D BY REGISTRAR <i>[Signature]</i> | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i> | |
| DATE <i>SEP 2 '58</i> | | | |

2066193XV5

9019

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Charles MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Alton La Plata | | | | c. LENGTH OF STAY IN 1b Lifetime | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicans Memorial Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First George Middle Arthur Last PILKERTON | | | | 4. DATE OF DEATH Month August Day 21 Year 1958 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH July 29, 1884 | |
| 9. AGE (In years last birthday) yrs. 74 | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | | | 10b. KIND OF BUSINESS OR INDUSTRY Farming self Emp. | | 11. BIRTHPLACE (State or foreign country) Charles County | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Columbus Pilkerton | | | | 14. MOTHER'S MAIDEN NAME Mamie E. Davis | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Leon Pilkerton (Son) Bel Alton, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Congestive Cardiac Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Coronary Heart Disease DUE TO (c) Acute Perforation Duodenal Ulcer & Peritonitis | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 2 YRS 6 DAYS |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from AUG. 15 , 19 58 , to AUG. 21 , 19 58 , that I last saw the deceased alive on AUG. 21 , 19 58 , and that death occurred at 5:20 A.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE J. Parran Jarboe M.D. | | | | ADDRESS (Street, city or town, state) La Plata, Md. | | | |
| DATE SIGNED 8-21-58 | | | | | | | |
| PHYSICIAN'S NAME (Type) J. PARRAN JARBOE, M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Aug. 23, 1958 | | 22c. NAME OF CEMETERY OR CREMATORY St. Thomas Cemetery | | 22d. LOCATION (City, town, or county) (State) Chapel Point, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Archart Funeral Home, Inc. | | | | ADDRESS La Plata, Md. | | 24a. REC'D BY REGISTRAR DATE AUG 27 '58 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Hume | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: All of this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9020

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u> | | c. LENGTH OF STAY IN 1b <u>4 days</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physician Memorial Hospital</u> | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Nanjemoy</u> | |
| f. STREET ADDRESS <u>1</u> | | g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>MINNIE</u> Middle <u>W.</u> Last <u>SANDERS</u> | | 4. DATE OF DEATH Month <u>AUG</u> Day <u>8</u> Year <u>1958</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1 Sept 1875</u> |
| 9. AGE (In years last birthday) <u>82</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Berry W. Walter Miltstead</u> | | 14. MOTHER'S MAIDEN NAME <u>Baxter</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>Worthy W. Sanders, Doncaster, Md.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral vascular accident</u> DUE TO (c) <u>Hypertensive Cardiovascular disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>443X</u> | | | |
| INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>4 days</u> <u>years</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>June</u> , 19 <u>48</u> , to <u>8 Aug</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8 August</u> , 19 <u>58</u> , and that death occurred at <u>9:43 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Sanwood Clinic</u> DATE SIGNED <u>8 Aug 58</u> ACTUAL SIGNATURE <u>Arthur O. Woody</u> PHYSICIAN'S NAME (Type) <u>ARTHUR O. WOODY, MD. La Plata, Maryland</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> | | 22b. DATE THEREOF <u>8/10/58</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Chicamuxen M.E.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Chicamuxen, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md.</u> | | 24a. REC'D BY REGISTRAR <u>AUG 12 1958</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Luther A. Prange</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10
CERTIFICATE OF DEATH

10000



Form with multiple lines for text entry, including fields for name, date, and other details. The text is faint and mostly illegible due to the quality of the scan. Some visible text includes 'NAME', 'DATE', and 'PLACE OF BIRTH'.

RECEIVED
BALTIMORE
MAY 10 1910

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9021

CERTIFICATE OF DEATH

69020

Reg. Dist. No.

| | | | |
|---|---------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Charles MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata | | c. LENGTH OF STAY IN 1b 5 Years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) William First Cooper Middle SCHAFER Last | | 4. DATE OF DEATH AUGUST 28 Month 28 Day 1958 Year | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 13, 1894 |
| 9. AGE (In years last birthday) 64 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Salesman | |
| 11. BIRTHPLACE (State or foreign country) Chica go, Ill. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Henry Schafer | | 14. MOTHER'S MAIDEN NAME Ann Howe | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W. L | | 16. SOCIAL SECURITY NO. 187-22-3093 | |
| 17. INFORMANT Mrs. Virginia Schafer (Wife) | | Address La Plata, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO CORONARY OCCLUSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH 10 hrs | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 1957 to Aug 28, 1958 , that I last saw the deceased alive on 23 Aug, 1958 , and that death occurred at 1:20 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE F. M. JOHNSON M.D. | | ADDRESS (Street, city or town, state) La Plata, Md. DATE SIGNED 8-28-58 | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL-Removal 8/30/58 | | 22b. DATE THEREOF | |
| 22c. NAME OF CEMETERY OR CREMATORY Alagany Cemetery | | 22d. LOCATION (City, town, or county) (State) Pittsburgh, Pennsylvania | |
| 23. FUNERAL DIRECTOR'S SIGNATURE AREHART FUNERAL HOME, INC. LA PLATA, MARYLAND | | 24a. REC'D BY REGISTRAR SEP 2 '58 | |
| 24b. REGISTRAR'S SIGNATURE Arthur L. Kraus | | | |

CERTIFICATE OF DEATH

Page 1

| | | | | | |
|--|--|--|--|---|--|
| Name of Deceased | | Sex | | Age | |
| Date of Birth | | Date of Death | | Time of Death | |
| Place of Birth | | Place of Death | | Cause of Death | |
| Occupation | | Residence | | Manner of Death | |
| Signature of Physician | | Signature of Registrar | | Signature of Coroner | |
| Signature of Medical Examiner | | Signature of Health Officer | | Signature of City Clerk | |
| Signature of County Clerk | | Signature of State Registrar | | Signature of State Health Officer | |
| Signature of State Surgeon | | Signature of State Auditor | | Signature of State Treasurer | |
| Signature of State Comptroller | | Signature of State Attorney General | | Signature of State Superintendent of Education | |
| Signature of State Commissioner of Labor | | Signature of State Commissioner of Agriculture | | Signature of State Commissioner of Fish and Game | |
| Signature of State Commissioner of Mines | | Signature of State Commissioner of Public Safety | | Signature of State Commissioner of Transportation | |
| Signature of State Commissioner of Social Services | | Signature of State Commissioner of Mental Health | | Signature of State Commissioner of Alcoholism | |
| Signature of State Commissioner of Narcotics | | Signature of State Commissioner of Child Welfare | | Signature of State Commissioner of Public Health | |
| Signature of State Commissioner of Hospitals | | Signature of State Commissioner of Sanitation | | Signature of State Commissioner of Food and Drug | |
| Signature of State Commissioner of Fire and Marine Insurance | | Signature of State Commissioner of Banking and Finance | | Signature of State Commissioner of Insurance | |
| Signature of State Commissioner of Real Estate | | Signature of State Commissioner of Motor Vehicle | | Signature of State Commissioner of Aeronautics | |
| Signature of State Commissioner of Public Works | | Signature of State Commissioner of Public Utilities | | Signature of State Commissioner of Public Buildings | |
| Signature of State Commissioner of Public Parks | | Signature of State Commissioner of Public Recreation | | Signature of State Commissioner of Public Safety | |
| Signature of State Commissioner of Public Health | | Signature of State Commissioner of Public Health | | Signature of State Commissioner of Public Health | |

RECEIVED
JAN 10 1918
BALTIMORE

9022

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH o. COUNTY <u>Charles</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Charles</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Benedict</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Benedict</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) <u>IDA MAY TOYE</u> | | 4. DATE OF DEATH Month <u>Aug</u> Day <u>25</u> Year <u>1958</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>C</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec 15, 1865</u> |
| 9. AGE (In years last birthday) <u>92</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>self</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Agustus Savoy</u> | | 14. MOTHER'S MAIDEN NAME <u>Josie Tyler</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | |
| 17. INFORMANT <u>EVERETT TOYE</u> | | Address <u>Benedict MD</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Cardiac Failure</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 YR.</u> <u>3 YR.</u> |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>57</u> , to <u>Aug 24</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Aug 24</u> , 19 <u>58</u> , and that death occurred at <u>12:00 PM EST</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>J. Parran Jarboe</u> | | DATE SIGNED <u>8-25-58</u> | |
| PHYSICIAN'S NAME (Type) <u>J. PARRAN JARBOE</u> | | ADDRESS (Street, city or town, state) <u>La Plata, Md</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>Aug 28 1958</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>St Peter's</u> | 22d. LOCATION (City, town, or county) (State) <u>Waldorf MD</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Huntt Funeral Home</u> | | 24a. REC'D BY REGISTRAR DATE <u>SEP 2 '58</u> | |
| ADDRESS <u>Waldorf MD</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9023

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAPLATA | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PHYSICIANS MEMORIAL HOSP. | | | | d. STREET ADDRESS 1 | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First John Middle W. Last TROTTER | | | | 4. DATE OF DEATH Month AUGUST Day 9 Year 1958 | | | |
| 5. SEX Male | | 6. COLOR OR RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 3 APRIL 1958 | |
| 9. AGE (In years last birthday) yrs. 4 | | IF UNDER 1 YEAR Months 6 | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Howard E Trotter Jr | | | | 14. MOTHER'S MAIDEN NAME Mary M. Simpson | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT Address Howard E. Trotter Jr, Waldorf, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure 7545 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive heart failure DUE TO (c) Congenital defect of heart PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 min 3 wks. 4 months | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 3 April , 19 58 , to 9 August , 19 58 , that I last saw the deceased alive on 9 August , 19 58 , and that death occurred at 10:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) LAPLATA, MARYLAND DATE SIGNED 10 August 58 ACTUAL SIGNATURE Arthur O. Woody M.D. PHYSICIAN'S NAME (Type) ARTHUR O. WOODY | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| Burial | | 8/12/58 | | St Peters | | Waldorf, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md. | | | | ADDRESS 24a. REC'D BY REGISTRAR DATE AUG 13 '58 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Kraus | |

2066 333XV4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: All of this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JAN 20 1914

CERTIFICATE OF DEATH

1913

John W

Howard E Trotter Jr May 11 2 m 1913
Howard E Trotter Jr Waldorf, Md

The Heart Line of Howard E Trotter Jr
Born 8/15/88 at Peters
Waldorf, Md

CERTIFICATE OF DEATH

Reg. Dist. No.

09023

| | | | |
|--|-------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LATIMARA | | c. LENGTH OF STAY IN 1b 3 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Physicians Memorial Hospital | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Lola First Whalen Middle Whalen Last | | 4. DATE OF DEATH August 23 Month 1958 Day Year | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH ? 1900 58 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY — | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Wesley Brown | | 14. MOTHER'S MAIDEN NAME Josephine ? | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. No | |
| 17. INFORMANT Randolph Whalen, Newburg, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Collapse 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastasis of Carcinoma of bladder DUE TO (c) 5 years. | | INTERVAL BETWEEN ONSET AND DEATH 12 hrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 18 Aug., 1958 , to 23 Aug., 1958 , that I last saw the deceased alive on 23 Aug., 1958 , and that death occurred at 5:36 A.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Arthur O. Woody | | ADDRESS (Street, city or town, state) La Plata, Md. | |
| PHYSICIAN'S NAME (Type) ARTHUR O. WOODY | | DATE SIGNED 23 Aug 58 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8/26/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY John Wesley | | 22d. LOCATION (City, town, or county) (State) Chaptico, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf Md | | ADDRESS | |
| 24a. REC'D BY REGISTRAR SEP 2 '58 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1924

1. Name of deceased: John W. Brown

2. Sex: Male

3. Age: 45

4. Date of birth: March 1, 1879

5. Date of death: March 1, 1924

6. Place of death: Home, Baltimore, Md.

7. Cause of death: Heart failure

8. Signature of physician: Chapman W. J.

9. Signature of registrar: Chapman W. J.

10. Signature of undertaker: Chapman W. J.